Clark County Regional Support Network

Inpatient Authorization Form

Authorization #: 88 _____ 424

I. CALLER INFORMATION

Date:_____ Time of Call or Page:_____ AM/PM Time of CM Response:_____ AM/PM
(mm/dd/yy)

Caller Name:_____Agency: _____ Phone: _____
(last) (first)

II. CONSUMER INFORMATION

Consumer Name:_____ DOB: _____ AGE: _____
(last) (first) *(mm/dd/yy)*

SSN: _____ - _____-_____ Ethnicity: _____ Medicaid PIC #_____

Consumer Address: _____

Diagnosis Code and Name: _____

AXIS I: _____

AXIS II: _____

Medications:

_____

Prescribed By: Agency:

III. MEDICAL NECESSITY (Risk Assessment/Acuity/Function/Support/Environment)

_____

_____

_____

_____

_____

_____

Current Substance Abuse? ❑ YES ❑ NO Identify Substance(s): _____

Current Substance Abuse Treatment? ❑ YES ❑ NO Where/Agency? _____

Current Outpatient Treatment? ❑ YES ❑ NO Where/Agency? _____

PCP/CM _____Consulted? ❑ YES ❑ NO

History of Suicidal/Homicidal Gesture/Attempts? ❑ YES ❑ NO If yes, describe:_____

_____

History of Hospitalization? ❑ YES ❑ NO If yes, describe:_____

Alternatives/Diversion Explored? ❑ YES ❑ NO If yes, describe:_____

IV. GOAL(s) FOR HOSPITALIZATION: _____

_____

_____

V. INPATIENT AUTHORIZATION CRITERIA - Person must meet criteria 1 or 2 ***AND*** 3 through 6:

1 ☐ Person is exhibiting imminent risk of suicide or homicide due to a mental disorder.

2 ☐ Person is not intoxicated OR there is documented evidence that mental health symptoms would persist beyond intoxication.

3 ☐ Person is functionally impaired and presenter is able to provide evidence of extreme functional impairment.

4 ☐ Less restrictive mental health alternatives have been ruled out based on clinical considerations and availability of resources.

5 ☐ The primary symptoms are consistent with a covered mental health condition.

6 ☐ The hospitalization does not appear to be related to a need for housing, community support or urgent access to outpatient services.

If authorization is denied, additional comments: _____

_____

VI. PSYCHIATRIC CONSULTATION (Required for child and adolescent *authorization* requests.):

Name of Consultant:: _____

Time Called Consultant: _____ Time Call Returned: _____ By Consultant: _____

Results of Consult: _____

_____

VII. DISPOSITION

☐ AUTHORIZED Admitted to: _____ Date: _____

☐ DIVERSION Diversion Plan: _____

☐ DENIED

EXPEDITED REVIEW: ☐ YES ☐ NO If yes, see Expedited Review form.

SIGNATURE

Care Manager: _____ Printed Name: _____

Date and time of authorization decision: _____ AM/PM
(date) (time)

Clark County Regional Support Network

In-Patient Authorization
Expedited Review Form

Review Requested By: _____ ___Agency: _____

Time Called MD: _____Time Call Returned: _____By MD: _____

MD Recommendations: _____

_____

_____

_____

_____

_____